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The Impact of Preventive Home Care and Seniors Housing on Health Outcomes

This study evaluated the effectiveness of two supportive services available to Saskatchewan seniors: preventive home care and senior social housing (seniors housing). Preventive home care provides seniors living in the community with support services such as homemaking, personal care, and meals. It is a lighter level of care than other forms of home care such as post-acute home care (which includes intensive nursing, personal care, homemaking, and other services following hospital discharge) or nursing home substitution (which includes intensive nursing, personal care, and homemaking, and other services designed to substitute for or delay admission to nursing home). Seniors housing is government-subsidized housing for seniors.

We studied administrative data on 26,490 Saskatchewan seniors aged 75 and older, to determine whether those seniors who received these services lived longer and remained independent (defined in our study as being alive and not living in a nursing home) longer than those who lived in the community but did not receive these services. We then compared the health care costs of service recipients with those of non-recipients.

After adjusting for health status and use of other health services, we found Saskatchewan seniors receiving preventive home care were 50 per cent more likely to lose their independence or die than those not receiving any service. As well, the average total health service costs for preventive home care recipients were approximately triple the average total costs for non-recipients. Residents of seniors housing, however, were 63 per cent less likely to lose their independence and 40 per cent less likely to die than other Saskatchewan seniors. Residents of seniors housing had about the same total health service costs as non-residents. While more research is needed to fully evaluate these services, our findings suggest seniors housing is more effective than preventive home care in keeping seniors alive and out of nursing homes, and results in lower overall health service costs.

Our study had three main limitations. First, our use of administrative data may have created a potential for selection bias. Although we attempted to control for this by adjusting for many characteristics believed to affect outcomes, the database we used contained a limited number of variables. Thus we were unable to fully adjust for some characteristics—particularly pre-existing functional limitations. A second limitation was that we were able to examine only those outcomes captured in administrative data. We were unable to evaluate whether the support services affected important outcomes such as seniors' ability to perform specific activities of daily living, their quality of life, or caregiver burden. Finally, we did our costing analysis from a health system perspective and included only health system costs. Additional costs, such as those incurred by Saskatchewan Housing and out-of-pocket payments made by seniors and their families, were not included in this analysis.

While our research is an important step in evaluating preventive home care and seniors housing, we recommend additional studies be done to confirm and extend our findings. That said, our findings do suggest that preventive home care may inadvertently increase a senior's risk of death or loss of independence. Until subsequent research finds otherwise, we recommend that preventive home care be delivered only to those seniors most at risk for death or loss of independence.

Introduction

One of the most hotly debated issues in home care is the effectiveness of preventive home care. Preventive home care provides seniors living in the community with support services such as homemaking, personal care, and meals. It is a lighter level of care, distinct from other home care services such as post-acute home care (which includes intensive nursing, personal care, homemaking, and other services following hospital discharge) or nursing home substitution (which includes intensive nursing, personal care, and homemaking, and other services designed to substitute for or delay admission to nursing home). The rationale for preventive home care is that providing seniors with these support services will help extend the time they are alive and living independently (i.e., outside a nursing home). To date, however, preventive home care is as much a hypothesis as a description, and while the rationale may seem logical, it is unproven.

Over the years, home care managers have expanded or reduced preventive home care activities in response to provincial policy and directives, funding availability, and the preferences of local governing boards. Now that the provincial government has sent strong and consistent signals that home care should be expanded—its budget has almost doubled in the last five years—the opportunities to expand preventive home care are great. But the need to answer questions about its effectiveness is even more pressing.

In reviewing the literature on the cost effectiveness of home care, we found four studies on preventive home care that met our criteria for review (e.g., adequate sample size and methodology). These studies generally reported equal or improved outcomes for people receiving preventive home care. Although three suggested preventive home care saves money, weaknesses in their costing methods reduced our confidence in the findings. Furthermore, all three studies evaluated preventive services offered to frail, elderly patients being discharged from the hospital. The fourth study we reviewed evaluated preventive home care provided to community living seniors. It found that providing the service reduced seniors' chances of admission to a nursing home, but resulted in higher overall costs. The question thus remains: Does preventive home care work? Does it lead to better outcomes and, if so, at what costs to the health system?

Based on consultations with health districts in 1995, we elected to study the cost-effectiveness of three types of home care: 1) as a substitute for hospital care; 2) as a preventive service aimed at reducing long-term health care use; and, 3) as a substitute for nursing home care. We convened a group of representatives from seniors housing, acute, long-term, and home care services, and a consumer representative to oversee all three studies. This report presents the second study: home care as a preventive service aimed at reducing long-term health service use.

We expanded our research to include a simultaneous exploration of senior social housing (seniors housing). Seniors housing is subsidized social housing available to seniors in approximately 280 Saskatchewan communities. Applicants are rank ordered based on income, health, and social needs, and rent is charged at a rate of 25 per cent of household income. Actual arrangements vary by community, but may include housing in a duplex, fourplex, townhouse, or high-rise.

Methods

Research questions

Our primary aim was to determine whether the supportive services of preventive home care and seniors housing are effective in helping seniors live and remain independent longer (i.e., alive and not living in a nursing home) than similar seniors not receiving the services?

Because we were constrained by the limited information available in the administrative data, our definition of "loss of independence" does not take into account such factors as an individual's ability to carry out regular day-to-day activities. Although this definition may seem narrow, delaying admission to a nursing home is, in fact, a major goal of both supportive services.

We also wanted to find out if service recipients have lower annual health service costs (including physician visits, hospitals, nursing homes, home care, and prescription medication) than seniors not receiving these services.

Study design

Using administrative data from Saskatchewan Health and Saskatchewan Housing Corporation we

designed an observational cohort study. A detailed description of our methods is available on our website (www.sdh.sk.ca/hsurc). In summary, we:

- Obtained eight years (1989/90–1996/97) of anonymous data on all Saskatchewan seniors, aged 75 and older as of July 1, 1991. The data described each person's use of hospitals, physicians, long-term care, special care homes, home care, and prescription medication.
- Adjusted for factors other than preventive home care and seniors housing that affect how long a senior lives, or remains independent (such as age, sex, and health status).
- Used a statistical technique called survival analysis to test whether seniors receiving preventive home care and residing in seniors housing lived longer or lived independently longer than seniors not receiving these services.
- Confirmed these results using a second statistical method called propensity score analysis.
- Compared total costs of all health services used by service recipients and non-recipients (hospitals, physicians, special care homes, home care, and prescription drugs) from the study start to the time of death, loss of independence, or the end of the study.

Saskatchewan Health maintains administrative data on three types of home care (acute, supportive, and palliative) and on the different levels of care delivered to clients (coded 1 through 4, from lowest to highest). We defined preventive home care as supportive home care delivered to Level 1 or 2 clients (supervisory and personal care). We matched seniors housing data to health services data using Saskatchewan's unique health service identifier to flag seniors in our study population who lived in seniors housing.

Using survival analyses, we looked at the impact of preventive home care and seniors housing. This technique yields a risk ratio, which is an estimate of the effect of the variable of interest (in this case, preventive home care and seniors housing) on the outcomes of interest (in this case death and loss of independence by being admitted to a nursing home or dying). A relative risk of one means seniors who do and do not receive services are at equal risk. A relative risk of less than one indicates that seniors who receive the service have a lower risk than those who do not receive it, while a relative risk greater than one means seniors receiving the service are at greater risk than those not receiving the service.

Findings

Of the 26,490 seniors in our sample, 36 per cent (9,524) received preventive home care and nine per cent (2,484) were in seniors housing at some point in the study period. At our start date of July 1, 1991, 13 per cent were receiving preventive home care and six per cent were living in seniors housing. Fifty-seven per cent of our sample were female, 52 per cent were between the ages of 75 and 79, 31 per cent between 80 and 84, 13 per cent between 85 and 89, and the remaining four per cent were over age 90. At the end of the study period, 36 per cent of the sample had died and 45 per cent had lost their independence.

Preventive home care

Seniors receiving preventive home care were about 30 per cent more likely to die (relative risk 1.3) and 120 per cent more likely to lose their independence (relative risk 2.2) than seniors not receiving preventive home care (Table 1).

One would expect those seniors receiving home care to be less healthy and at a greater risk of dying or losing their independence (by death or admission to a nursing home) than those not receiving the service. We controlled for this by adjusting outcomes to take into account differences in previous health.

After adjusting for possible differences in their previous health, we found that seniors receiving preventive home care were about 20 per cent more likely to die and about 110 per cent more likely to be admitted to a nursing home than seniors not receiving these services.

Besides adjusting for previous health status, we also wanted to control for any differences in seniors' receipt of health services. When clients receive some health services, they are by definition excluded from receiving others. People who are admitted to a hospital or nursing home usually do not receive other services. A second reason for our making this adjustment was because current receipt of health services may be an indicator of poorer health. Thus, a senior in hospital is in worse health than a senior who is not in hospital.

After adjusting for differences in their receipt of health services, we found those seniors who received preventive home care were 70 per cent more likely to die and 120 per cent more likely to be admitted to a nursing home than seniors who did not receive preventive home care.

Finally, we adjusted for previous receipt of service. Receiving a health service, such as preventive home care, is both an indicator of poor health and an intervention designed to improve health. Although we adjusted for health status, administrative databases do not contain measures of functional ability. As a result, our analysis may not capture this measure. Poor functional ability, however, is precisely the health indicator at which preventive home care is most likely to be targeted. We would expect that those seniors who had previously received the service would be in worse health than new admissions to the service.

Even after adjusting for previous service history, seniors receiving preventive home care were at 50 per cent greater risk of both death and loss of independence than those not receiving the service.

In a further analysis, we examined whether the effect of preventive home care varied by a person's level of risk of death or loss of independence. To do this, we ranked people into five equal groups, according to their level of risk. People in the highest risk group and receiving preventive home care were still at greater risk for either death or loss of independence than people in the same risk group who were not receiving the service. Risk lessens, however, in the higher risk groups (Table 2).

Preventive home care consists mainly of meals, homemaking and personal care, and some limited registered nursing services—targeted primarily at moni-

Table 1. Estimated outcomes of preventive home care

Preventive home care	Relative risk* for:	
	Death	Loss of independence
• unadjusted	1.3	2.2
• adjusted for health risk	1.2	2.1
• adjusted for health risk and receipt of all other services in same quarter	1.7	2.2
• adjusted for health risk, receipt of all other services in same quarter, and any receipt of same service in previous two years	1.5	1.5

* compared to those not receiving the service.

Table 2. Estimated outcomes of preventive home care by risk group

Preventive home care	Relative risk* for:	
	Death	Loss of independence
• lowest risk group	1.8	2.1
• second risk group	1.4	1.9
• third risk group	1.4	1.6
• fourth risk group	1.4	1.5
• highest risk group	1.2	1.4

* compared to those in the same risk group but not receiving the service.

Table 3. Estimated outcomes of preventive home care by service type

Preventive home care sub-service analysed by thirds of service used	Relative risk* for:	
	Death	Loss of independence
• Nursing by a registered nurse		
▪ low (0-2 hours per three months)	1.7	1.9
▪ medium (2.1 to 5.25 hours three months)	2.3	2.4
▪ high (5.26 hours plus per three months)	3.1	3.2
• Homemaking and personal care		
▪ low (0-36.5 hours per three months)	**1.0	1.2
▪ medium (36.6 – 185.5 hours per three months)	0.9	1.1
▪ high (185.6 hours plus per three months)	0.7	0.8
• Meals		
▪ low (0-19 meals per three months)	**1.0	1.1
▪ medium (19.1-140 meals per three months)	0.9	1.1
▪ high (140.1 meals plus per three months)	0.9	**1.1

* compared to those not receiving the service
** not statistically significant

toring clients and teaching families to provide care for clients. *(Therapies are a fourth service offered under the preventive home care umbrella, however, in our data, this service accounted for less than one per cent of the service delivered, and has thus been excluded from this analysis.)* To further investigate our findings, we divided preventive home care into these three sub-services, then analysed each by quantity of service delivered over a three-month period (i.e., lowest, middle, or highest amount of units). After holding all other factors equal (i.e., adjusting for health status and receipt of other services in the same quarter), we found seniors receiving low, medium, or high levels of nursing preventive home care services were at greater risk for dying than seniors not receiving these services (Table 3). Seniors receiving medium or high levels of homemaking and personal care or meals were at a slightly lower risk of dying than seniors not receiving these services.

We did propensity score analyses of outcomes of preventive home care and seniors housing. The results (not shown here) confirmed our findings from the survival analyses.

Seniors housing

We also examined the effects of seniors housing on health outcomes, controlling for the same factors we did with preventive home care (Table 4). After fully adjusting the risks, we found that people living in seniors housing were 40 per cent less likely to die and 60 per cent less likely to lose their independence than those not living in seniors housing.

To better understand the impact of seniors housing, we calculated relative risk for each of the six years of follow-up (Table 5). We found that, in 1991-92, seniors living in seniors housing were 70 per cent less likely than those not living in seniors housing to die or lose their independence, but by 1996-97, this effect had diminished significantly.

Cost evaluation

Besides examining the effect of preventive home care and seniors housing on death and loss of independence, we also wanted to determine total health service costs for people receiving these services. Our

Table 4. Estimated outcomes of seniors housing

Seniors housing	Relative risk* for:	
	Death	Loss of independence
• unadjusted	0.5	0.7
• adjusted for health risk score	0.5	0.7
• adjusted for health risk score and receipt of all other services in same quarter	0.6	0.6
• adjusted for health risk score, receipt of all other services in same quarter, and any receipt of same service in previous two years	0.6	0.4

* compared to those not receiving the service

Table 5. Estimated outcomes of seniors housing by study year

Service year	Relative risk* for:	
	Death	Loss of independence
1991-92	0.3	0.3
1992-93	0.3	0.3
1993-94	0.6	0.6
1994-95	0.7	0.7
1995-96	0.8	**1.0
1996-97	0.7	**1.0

* compared to those not receiving the service
** not statistically significant

Table 6. Average total health service costs per person, to death or end of study, and to loss of independence or end of study, by preventive home care and seniors housing status

	To death or six years		To loss of independence or six years	
Service	**Received service**	**Did not receive service**	**Received service**	**Did not receive service**
Preventive home care				
Unadjusted	$49,273	$26,573	$35,047	$19,107
Adjusted*	31,257	9,045	22,925	7,259
Seniors housing				
Unadjusted	34,845	34,665	29,017	24,364
Adjusted*	17,677	13,677	15,522	10,509

* Because the data was skewed, we used the log of the costs in our analysis. Therefore, these results represent the geometric mean, which is the anti-log of the mean log of the costs.

Table 7. Average health service costs (unadjusted) per person over 6 years by endpoint and preventive home care status

Cost category	To death		To loss of independence	
	Preventive Home Care	No Preventive Home Care	Preventive Home Care	No Preventive Home Care
Total	**$49,273**	**$26,573**	**$35,047**	**$19,107**
Physician	2,810	2,144	2,513	1,986
Home care	5,181	585*	5,181	585*
• nursing	1,065	132	1,065	132
• homemaking/ personal care	3,307	407	3,307	407
• therapy	30	7	30	7
• meals	779	39	779	39
Nursing home	12,387	6,435	864	277
• LTC	11,444	6,126	0	0
• Respite	231	100	214	90
• Adult day care	432	122	403	113
• Other	280	87	247	74
Hospital	26,135	15,707	24,122	14,730
Drug	2,761	1,702	2,368	1,529

*Seniors in the "no preventive home care group" may still have received other home care services (e.g., acute or palliative home care services), and would thus still have home care costs.

costs are expressed in 1991 dollars, with figures after 1991 discounted at a rate of five per cent per year. Even after adjustment for other characteristics (such as age, and sex) that affect health services costs, total health services costs for seniors receiving preventive home care were twice those of seniors not receiving the service—both over the six years and to time of death or loss of independence. Total health service costs (to death or loss of independence) were about the same for those people living in seniors housing and those not (Table 6).

Hospital stays were the most costly service received across all groups. Among seniors who received preventive home care, nursing home services were the second largest expense to death or end of study, while home care services were the second largest expense to loss of independence or end of study (Tables 7 and 8).

Conclusions and Discussion

This study explored the effectiveness and the costs associated with preventive home care and seniors housing. Based on our analyses, we drew the following conclusions:

Preventive home care

- Seniors receiving preventive home care are more likely to die or lose their independence than seniors not receiving this service.
- Seniors receiving high amounts of homemaking have a slightly reduced risk of death and loss of independence.
- If preventive home care is of any benefit, it is likely among those seniors most at risk of death or loss of independence.

Table 8. Average health service costs (unadjusted) per person over 6 years by endpoint and seniors housing status

Cost category	To death		To loss of independence	
	Seniors Housing	No Seniors Housing	Seniors Housing	No Seniors Housing
Total	$34,845	$34,665	$29,017	$24,364
Physician	2,677	2,351	2,554	2,135
Home care	3,976	2,046	3,976	2,046
• Nursing	804	430	804	430
• Homemaking/personal care	2,431	1,341	2,431	1,341
• Therapy	24	14	24	14
• Meals	717	261	717	261
Nursing home	5,459	8,884	604	474
• LTC	4,820	8,358	0	0
• Respite	101	152	98	138
• Day care	160	156	150	134
• Other	378	218	356	202
Hospital	20,132	19,359	19,456	17,943
Drug	2,601	2,026	2,427	1,767

Seniors housing

- Residents of seniors housing have a lower risk of death or loss of independence than non-residents.
- The positive effects of the seniors housing program were stronger in 1991 to 1993, the first two years of the study.

Costs

- Seniors receiving preventive home care have higher health service costs than seniors not receiving the service. This higher cost is not due solely to the cost of delivering the preventive home care.
- Health service costs for residents of seniors housing were virtually the same as those for non-residents.

Our results suggest that receiving home care services, especially if you're a senior not at high risk of death or loss of independence, actually increases risk. This finding, which runs counter to accepted wisdom, should prompt policy-makers and home care managers to rethink their assumptions about preventive home care.

Why might preventive home care increase a senior's risk of adverse outcomes? We offer three possible explanations:

1) Our study suggests that people benefit from living in seniors housing. Seniors housing includes collective housing, where a senior lives in close proximity (often in the same building) to others. Home care services, on the other hand, are often initiated when an elderly person who is living alone becomes frail. Seniors who are both frail and living alone may feel isolated, which in turn can lead to depression and poor nutrition (direct causes of poor health outcomes). Perhaps preventive home care con-

tributes to this isolation and subsequent deterioration, by enabling a frail senior to remain in an isolated, lonely, living environment.

2) A second possible explanation is that receiving home care may produce an observation effect. Seniors who have a home care worker coming into their home may have other unmet needs identified, leading to additional contact with the health system. If these needs are met inappropriately (for example, through unnecessary hospitalization or nursing home admission), a seniors' health status may worsen. We know that seniors living in rural areas were more likely to receive preventive home care and be hospitalized. During the study period, hospital beds in rural areas were commonly used for non-acute observation and for long-term supportive care. In addition, the long-term care funding formula (a per-bed-filled payment) provided administrators with the incentive to ensure institutional beds were always full. We know from our previous research that removing acute care funding from rural hospitals did not lead to adverse health outcomes (www.sdh.sk.ca/hsurc/completed project/hospital utilization patterns/).

3) Finally, providing preventive home care to clients at low risk of death or loss of independence may create a dependency. Clients who accept the service may start believing they are no longer able to cope or care for themselves. This in turn may lead to low morale, depression, and decrease of normal functioning, all of which contribute to poor health outcomes. Perhaps when preventive home care is readily available, providers are more likely to offer it to low-risk seniors. While well-meaning providers may be offering these services with the best of intentions, this may actually have a negative effect on an elderly person.

More research needs to be done into the impact that isolation, observation, and dependency effects have on seniors' risk of death and loss of independence. Further research in this area should also focus on those seniors who refuse preventive home care services because they want to manage their own care in their own home. Such studies may enhance our understanding of the factors (such as a senior's resiliency or a strong informal support system, for example) that improve health outcomes. Good databases are needed to capture the myriad of variables involved when care is provided outside the walls of an institution.

Our findings show that the positive effect of living in seniors housing diminished over time. This does not suggest that housing is not an important determinant of health, but rather that the positive effects of this particular housing strategy diminished over time. Discussions with seniors housing managers suggest that the diminishing effect may reflect a number of changes (to policy and service delivery) that occurred within the health and housing systems during the study period. In effect, these changes resulted in frailer seniors being admitted to seniors housing and remaining longer in seniors housing (rather than moving into nursing homes). Housing policy changes were made so that, in addition to considering household income and adequacy of current accommodation, the impact of current housing on health and social conditions was also considered for acceptance into seniors housing. An enriched housing program, which included health services, tenant monitoring, safety and security programs and co-ordination of social and recreational programs for tenants, was introduced in 1991 to accommodate and support seniors with higher level needs. Health care restructuring and the closure of light care facilities and rural hospitals in the early 1990s also contributed to the number of frail seniors moving into social housing. As well, increases in community care services have enabled tenants to remain living in social housing as they age rather than move into health care facilities. Over the last decade, these factors have resulted in an older, frailer population of tenants who live in social housing for a longer period of time. For example, in 1991, just over 40 per cent of tenants were aged 75 to 79, and only 24 per cent were age 85 and older. By 1997, 25 per cent of tenants were between the ages of 75 and 79 and 41 per cent were over the age of 85.

Our study design had three main limitations that may have affected the validity of our results. First, our use of administrative data to compare groups of individuals who received or did not receive preventive home care and seniors housing may have created a potential for selection bias. That is, the characteristics of one group could have differed from those of the other group because of factors other than receipt/non-receipt of a service (i.e., we may have been comparing apples to oranges). We attempted to control for selection bias by adjusting for many other characteristics (such as age, gender, hospital admissions etc.) that

were believed to affect the outcomes. However, because the database we used contained a limited number of variables, we were unable to fully adjust for some characteristics—particularly pre-existing functional limitations.

A second limitation is that we were only able to study outcomes captured in the administrative data. As a result, we defined "loss of independence" as death or admission to a nursing home, rather than on the basis of seniors' ability to perform specific activities of daily living, or their quality of life, or the ability of the services to address caregiver burden. Additional research is needed to evaluate the impact of preventive home care and seniors housing using these outcomes.

A final limitation is that our costing analysis was done from a health system perspective, and therefore included only health system costs. Additional costs, such as those incurred by Saskatchewan Housing and out-of-pocket payments made by seniors and their families, were not included in this analysis. More research is needed to identify other costs associated with receiving preventive home care and living in seniors housing.

Recommendations

Researchers

1. **Researchers should continue to evaluate preventive home care services.**
   - The findings we report here should be confirmed using other study designs and populations. As well, researchers should evaluate the effect of preventive home care and social housing on seniors' quality of life, functional ability, and caregiver burden, and examine the relationship between social isolation, preventive home care use, and death and loss of independence.

Saskatchewan Health

1. **Saskatchewan Health, in collaboration with the province's health districts, should establish a database to help districts monitor and evaluate home care programs.**
   - The health department's existing home care database should be expanded to include additional dimensions (e.g., a measure of functional ability) useful in evaluating the service.
   - To enable evaluation across districts and throughout the province, districts should deliver services according to minimum standards, and collect data using standard definitions and criteria. Saskatchewan Health could facilitate this by establishing and implementing standardized criteria for service delivery, as well as tools for assessing seniors' risk of home care admission.
   - Saskatchewan Health should establish and implement standardized criteria and tools for classifying levels of care. These criteria and tools should reflect common databases, enhancing the continuum and integration of care.
   - Saskatchewan Health should provide feedback to health districts, so they can establish benchmarks for performance. This feedback might include reporting (by level of care classification) the proportion of seniors in each district receiving home care, long-term care and seniors housing. Such information may serve as a preliminary indicator of inefficiencies and inequalities in district home care programs.

Health Districts

1. **Case managers and home care program managers should target preventive home care to high-risk seniors.**
   - In order to target services, health districts may wish to consider reassessing their current caseloads for eligibility and implementing a risk assessment tool to assess eligibility of future referrals.
2. **Case managers and home care program managers should take into account living environments and social isolation when assessing seniors' service needs.**
   - Case managers and home care program managers completing the comprehensive assessment of client needs should place added emphasis on the potential effect of living environments and social isolation on the client's health outcomes.

- To address the issue of isolation, health districts should foster collaborative programs with community-based organizations and other service groups to provide services to seniors aimed at increasing social contacts.
- When care planning, case managers and home care program managers should consider housing options that may decrease social isolation thereby supporting and promoting the health of the elderly population.
- Case managers and home care program managers should continue to educate clients and their families about the potential consequences of social isolation. Individuals eligible for seniors housing and who would be at risk of isolation—regardless of whether or not they received preventive home care—should be encouraged to consider social housing as an option.

Saskatchewan Housing Corporation

1. **Saskatchewan Housing Corporation should assess the impact policy or service changes may have on client outcomes.**
   - We found that the positive effects of the social housing program have diminished over time. Saskatchewan Housing Corporation should evaluate the factors that have contributed to this trend.

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Disclaimer

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Further Information

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This report and a companion document detailing our study methods are available on the HSURC website: http://www.sdh.sk.ca/hsurc.